SERFF Tracking Number:	*AMFA-125577585*	*State:*	*Arkansas*
Filing Company:	*Ameritas Life Insurance Corp.*	*State Tracking Number:*	*38510*
Company Tracking Number:			
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Audiology-ALIC-9021 Trust*		
Project Name/Number:	*/*		

Filing at a Glance

Company: Ameritas Life Insurance Corp.

Product Name: Audiology-ALIC-9021 Trust	SERFF Tr Num: AMFA-125577585	State: ArkansasLH
TOI: H10G Group Health - Dental	SERFF Status: Closed	State Tr Num: 38510
Sub-TOI: H10G.000 Health - Dental	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Authors: Janis Landon, Pat Peterson	Disposition Date: 03/31/2008
	Date Submitted: 03/25/2008	Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Pending
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: Resubmission	Previous Filing Number: AMFA 125485830
Group Market Size: Small and Large	Overall Rate Impact:
Group Market Type: Employer	Filing Status Changed: 03/31/2008
	State Status Changed: 03/31/2008
Deemer Date:	Corresponding Filing Tracking Number:

Filing Description:

AMERITAS LIFE INSURANCE CORP.

NAIC No.: 943-61301

FEIN No.: 47-0098400

Cover Pages - 9021 Trust Rev. 03-08 – Group Insurance Certificate Cover

SERFF Tracking Number:	*AMFA-125577585*	*State:*	*Arkansas*
Filing Company:	*Ameritas Life Insurance Corp.*	*State Tracking Number:*	*38510*
Company Tracking Number:			
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Audiology-ALIC-9021 Trust*		
Project Name/Number:	*/*		

The above referenced page was approved on 2/25/2008 by your department. It has come to our attention that there was a typo on the form number on the original page that was submitted. The form number has been corrected to read 9021- Trust Rev. 03-08 and we are resubmitting this form only.

We apologize for this oversight and thank you for reviewing the corrected form. If you need anything additional, please feel free to contact me at 800-745-1112, ext. 87997, FAX 402-467-7956 or email jlandon@ameritas.com.

Janis Landon
Contract Analyst

Company and Contact

Filing Contact Information

Janis Landon, Contract Analyst	jlandon@ameritas.com	
5900 O Street	(800) 745-1112 [Phone]	
Lincoln, NE 68501-1889	(402) 467-7956[FAX]	

Filing Company Information

Ameritas Life Insurance Corp.	CoCode: 61301	State of Domicile: Nebraska
5900 O Street	Group Code: 943	Company Type:
P O Box 81889		
Lincoln, NE 68501-1889	Group Name:	State ID Number:
(800) 756-1112 ext. [Phone]	FEIN Number: 47-0098400	

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	$50.00 per form
Per Company:	No

SERFF Tracking Number:	*AMFA-125577585*	*State:*	*Arkansas*
Filing Company:	*Ameritas Life Insurance Corp.*	*State Tracking Number:*	*38510*
Company Tracking Number:			
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Audiology-ALIC-9021 Trust*		
Project Name/Number:	*/*		

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Ameritas Life Insurance Corp.	$50.00	03/25/2008	18931468

SERFF Tracking Number:	*AMFA-125577585*	*State:*	*Arkansas*
Filing Company:	*Ameritas Life Insurance Corp.*	*State Tracking Number:*	*38510*
Company Tracking Number:			
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Audiology-ALIC-9021 Trust*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/31/2008	03/31/2008

SERFF Tracking Number:	*AMFA-125577585*	*State:*	*Arkansas*
Filing Company:	*Ameritas Life Insurance Corp.*	*State Tracking Number:*	*38510*
Company Tracking Number:			
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Audiology-ALIC-9021 Trust*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 03/31/2008
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AMFA-125577585*	*State:*	*Arkansas*
Filing Company:	*Ameritas Life Insurance Corp.*	*State Tracking Number:*	*38510*
Company Tracking Number:			
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Audiology-ALIC-9021 Trust*		
Project Name/Number:	*/*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Form	Group Insurance Certificate Cover	Approved-Closed	Yes

SERFF Tracking Number:	*AMFA-125577585*	*State:*	*Arkansas*
Filing Company:	*Ameritas Life Insurance Corp.*	*State Tracking Number:*	*38510*
Company Tracking Number:			
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Audiology-ALIC-9021 Trust*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number:

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	9021-Trust Rev. 03-08	Policy Jacket	Group Insurance Certificate Cover	Initial		50	9021-Trust-ALIC-Rev. 03-08.pdf

AMERITAS
LIFE INSURANCE CORP.
A UNIFI Company
A Stock Company
LINCOLN, NEBRASKA

GROUP [DENTAL] [EYE] [AND] [HEARING CARE] INSURANCE CERTIFICATE

The Policyholder **[Trustees of the *Name of Trust*]**

Policy Number [xxxxxx]

[Employer/Participating] Unit [Name of Unit]

[Insured Person John P. Specimen]

[Certificate Effective Date xx-xx-xxxx]
Refer to Exceptions on 9070]

[Class 1] **[Dept. 2]**

Ameritas Life Insurance Corp. certifies that you will be insured for the benefits described on the following pages, according to all the terms of the group policy numbered above which has been issued to the Policyholder.

Possession of this certificate does not necessarily mean you are insured. You are insured only if you meet the requirements set out in this certificate.

The group policy may be amended or canceled without the consent of the insured person.

The laws of the state in which the group policy was delivered govern the group policy and this certificate.

Jan M. Connolly — Secretary

JoAnn M Martin — President

SERFF Tracking Number:	*AMFA-125577585*	*State:*	*Arkansas*
Filing Company:	*Ameritas Life Insurance Corp.*	*State Tracking Number:*	*38510*
Company Tracking Number:			
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Audiology-ALIC-9021 Trust*		
Project Name/Number:	*/*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AMFA-125577585*	*State:*	*Arkansas*
Filing Company:	*Ameritas Life Insurance Corp.*	*State Tracking Number:*	*38510*
Company Tracking Number:			
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Audiology-ALIC-9021 Trust*		
Project Name/Number:	*/*		

Supporting Document Schedules

Satisfied -Name: Certification/Notice

Review Status: Approved-Closed 03/31/2008

Comments:

Attachments:

ar-readability-cert-alic-Trust only.pdf

ar-regulation 19-certification-alic-trust only filing.pdf

Satisfied -Name: Application

Review Status: Approved-Closed 03/31/2008

Comments:

Attachment:

Application.pdf

STATE OF ARKANSAS

CERTIFICATE OF READABILITY

INSURER: Ameritas Life Insurance Corp.

This is to certify that the attached form(s) has achieved a Flesch Reading Ease Score of:

FORM NO:	FLESCH SCORE:	FORM NAME:
9021 Trust-Rev. 03-08	47	Group Insurance Certificate Cover

complies with the requirements of Ark. Stat. Ann. Sections 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

SIGNATURE: Signature Not Verified Robert G. Lange Digitally signed by Robert G. Lange DN: cn=Robert G. Lange, c=US Date: 2008.03.25 09:31:21 -06'00'

TYPED NAME: Robert G. Lange
TITLE: Vice President and General Counsel - Insurance and Assistant Secretary

DATE: March 25, 2008

STATE OF ARKANSAS

REGULATION 19

INSURER: Ameritas Life Insurance Corp.

This is to certify that the attached form(s) are in compliance with Rule and Regulation 19:

Form Number:	**Form Name:**
9021-Trust Rev 03-08	Group Insurance Certificate Cover

SIGNATURE: Signature Not Verified Robert G. Lange Digitally signed by Robert G. Lange DN: cn=Robert G. Lange, c=US Date: 2008.03.25 09:29:38 -06'00'

TYPED NAME: Robert G. Lange

TITLE: Vice President, General Counsel and Assistant Secretary

DATE: 3/25/2008

application

for group dental and/or vision insurance

See reverse side for additional information.

AMERITAS LIFE INSURANCE CORP.
Lincoln, NE

1. Applicant's legal name _____

2. Doing business as _____

3.

_____
P.O. Box / ZIP Code

_____
Street Address

_____
City / State / ZIP

_____
Phone No. Fax No.

_____
E-mail Address Tax I.D. No.

4. What is the nature of your business or industry?

_____

_____

5. Eligibility

Total Number of Eligible Employees . . . . . _____

Employees in Waiting Period . . . . . _____

6. Are any classes or locations excluded? . . . . . ☐ Yes ☐ No

Are domestic partners included? . . . . . ☐ Yes ☐ No

Are retirees included? . . . . . ☐ Yes ☐ No

(If yes, please use reverse side for explanation.)

7. Are any subsidiary and/or affiliated companies to be insured? . . . . . ☐ Yes ☐ No

(If yes, please use reverse side to list name and location.)

8. How many hours per week equals full time employment? . . . . . _____

9. Employee Participation

Employer contributes _____% of employee premium.

☐ **Tied-to-Medical** (All employees covered on employer's medical plan must be insured, except those listed under excluded classes or locations.)

☐ **Non-Contributory** (Policyholder contributes 100% of premiums. All employees must be insured, except those listed under excluded classes or locations.)

☐ **Non-Contributory**, except covered elsewhere (If policyholder contributes 100% of premiums, all employees must be insured, except those listed under excluded classes or locations and those covered elsewhere.)

☐ **Contributory** (Policyholder is required to contribute to the employee premium and must contribute at least 25% of the total employee and dependent premium.)

☐ **Voluntary** (Policyholder does not contribute towards premium, 100% contribution by employee.)

10. Dependent Participation:

Employer contributes _____% of employee premium.

☐ **Tied-to-Medical** (All eligible dependents covered on employer's medical plan must be insured, except those listed under excluded classes or locations.)

☐ **Non-Contributory** (Policyholder contributes 100% of premiums. All eligible dependents must be insured, except those listed under excluded classes or locations.)

☐ **Non-Contributory**, except covered elsewhere (If policyholder contributes 100% of premiums, all eligible dependents must be insured, except those listed under excluded classes or locations and those covered elsewhere.)

☐ **Contributory** (Policyholder is required to contribute to the employee premium and must contribute at least 25% of the total employee and dependent premium.)

☐ **Voluntary** (Policyholder does not contribute towards premium, 100% contribution by employee.)

11. Section 125 Plan

Election Period _____

Plan Year _____

12. Employee welfare benefit plans that are subject to ERISA must satisfy various reporting, disclosure and related obligations. These requirements include the provisioning of a Summary Plan Description or SPD. The certificate of coverage can serve as an SPD if certain information is additionally disclosed. Please check one of the following (failure to respond shall be considered a positive response for A. and a negative response for B.).

A. ☐ **Plan is subject to ERISA (complete question 12.B.)**

☐ **Plan is NOT subject to ERISA — Church or Govt. employer or other safe-harbor exception** (see DOL Reg. §2510.3-1(j))

B. ☐ **Applicant requests that Ameritas Life Ins. Corp. prepare a SPD for its dental and/or vision plan** . . . . . ☐ Yes ☐ No

If yes, the company is to prepare a SPD. The following information is required under ERISA and MUST be included in the SPD.

Plan No. _____ Plan Fiscal Year _____

Plan Administrator:

Name: _____

Address: _____

City, State, ZIP _____

Phone No. _____ Plan Fiscal Year _____

Please Note: Applicant remains responsible for **ensuring** that SPD form provided by Ameritas Life Ins. Corp. is complete and accurate and satisfies applicable laws and regulations. Moreover, applicant remains responsible for providing its plan participants with SPD updates as required by applicable law and regulations.

13. Waiting Period

_____ for those employed on or before the policy effective date.

_____ for those employed after the new policy effective date.

☐ month(s) ☐ calendar days ☐ working days

14. Effective Date and Termination Date

☐ Immediate

☐ First of Month Effective date / End of Month Termination date

☐ Other _____

_____

15. Premium Payment Mode (In advance)

☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

☐ Payroll Deduction (To choose this option, employee must pay employee and dependent premium.)

If policy effective date is other than first of the month, is a first of the month premium due date desired? . . . . . ☐ Yes ☐ No

Billing Options

☐ Home Office ☐ Third-Party Administration

_____
Contact Name

_____
Title

_____
Street Address

_____
City / State / ZIP

_____
Phone No. Fax No.

_____
E-mail Address

16. The following coverages are applied for:
Employee & Dependents Benefits

☐ Dental ☐ Orthodontia ☐ Eye Care

☐ Other _____

Employee Only Benefits

☐ Dental ☐ Orthodontia ☐ Eye Care

☐ Other _____

This insurance shall be effective on: _____
(Premiums due prior to the coverage period.)

17. Policy and Certificate Delivery (select one)

A. eCert*/ePolicy (*generic cert, non-personalized)

☐ via PDF format sent via e-mail to:

_____

☐ via eService and member portal

B. Paper policy/personalized certificates

☐ Initial employees only

☐ Subsequently added employees

Note: eCert will be available on member portal for all members.

18. Insurance requested on this application will replace the coverage(s) checked.

Coverages: ☐ Dental ☐ Orthodontia ☐ Eye Care

☐ Other _____

Name of Current Carrier _____

Policy No. _____

☐ Coverage applied for is replacing comparable coverage now or previously in force with another carrier.

☐ It is intended that the insurance coverage applied for be in addition to, supplemented by, or supplemental to any similar coverage now in force, or to be in force, with this or any other carrier.

_____
Termination Date Original Effective date

Item 6: Exclusions

a. Classes, include reason for exclusion.

_____

_____

b. Locations, if location is different from applicant's, list city and state.

_____

_____

Item 7: Subsidiary and/or affiliated companies to be insured. List names and locations.

_____

_____

Plan Design and Proposed Rates: _____

_____

_____

Additional Remarks: _____

_____

_____

Agreements

This application will be subject to review and approval by the Home Office of Ameritas Life Insurance Corp. If this application is accepted, the final rates and benefits will be based on verification of this information and final enrollment numbers. This applicant represents that he/she has read the statements and answers to the above questions and that they are complete and true to the best of his/her knowledge and belief. Any policy including riders issued as a result of this application will, with this application, be the entire insurance contract. If this application is accepted at the Home Office of Ameritas Life Insurance Corp., group insurance at the Company's rates and under the terms applied for shall take effect as of the date set forth in the policy. If this application is not accepted, any premium advanced shall be refunded.

Statements

In several states, we are required to advise you of the following: Any person who knowingly and with intent to defraud provides false, incomplete, or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, is guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim. (See state-specific statements.) • **Note for California Residents:** California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage. For group policies issued, amended, delivered or renewed in California, dependent coverage includes individuals who are registered domestic partners and their dependents. • **Note for Colorado Residents:** It is unlawful to knowingly provide false, incomplete, or misleading facts for information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies. • **Note for Florida Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. • **Note for Kentucky Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. • **Note for New Jersey Residents:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. • **Note for Georgia, Kansas, Nebraska, Oregon, Vermont and Virginia Residents:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law. • **Note for Pennsylvania Residents:** Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

☐ **If you do not want your company name used by Ameritas Life Insurance Corp. in our effort to recruit PPO providers, check this box.**

Signed at: City _____ State_____ Date_____

Soliciting Agent: Printed Name _____ For FL agents only, provide FL license #_____

Signature _____

The policy provides dental and/or vision benefits only. Review your policy carefully.

Signed by (Policyholder Representative): Printed name and title _____

I understand and agree that if I'm not already appointed with Ameritas Life Insurance Corp., I must apply to and be appointed with Ameritas before I present this product to any client. Signature_____

Was a binder check received? ☐ Yes ☐ No If yes, then amount $_____.

Check received by (agent) _____ **Authorized by** (policyholder)_____

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO AMERITAS LIFE INSURANCE CORP.

DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK.